STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

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LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

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F 000	INITIAL COMMENTS Investigation of C/O #27877, #28165, #27036, and #27007 was conducted at Lebanon Health and Rehabilitation Center July 25 - 29, 2011, and August 1 - 3, 2011. No deficiencies were cited for C/O #27007 and #28165. Deficiencies were cited for C/O #27877 and #27036. Based on investigation of C/O #27877, the facility was cited Immediate Jeopardy. A partial extended survey was conducted on August 3, 2011. The Administrator and the Regional Clinical Director were informed of the Immediate Jeopardy in the conference room on July 29, 2011, at 11:15 a.m. The Immediate Jeopardy was effective from March 3, 2011, through August 3, 2011. Substandard Quality of Care was cited under F309K. An acceptable Allegation of Compliance, which removed the Immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on August 3, 2011. Non-compliance of the Immediate Jeopardy tags continues at a scope and severity of a "E" level for monitoring of correction actions. The facility is required to submit a plan of correction for all tags.	F 000		
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mona D McCord — TITLE: Administrator — (X6) DATE: 8/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 22 2011

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F 157	Continued From page 1 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the physician's on-call answering service log, facility policy review, emergency medical services	F 157	F157 **1. Residents identified to be affected by the alleged deficient practice.** The four residents identified to have been affected by the alleged deficient practice, #5, #12, #13 and #14, are no longer at the facility; therefore, no further action can be taken for these residents. **2. Residents who have the potential to be affected by the alleged deficient practice.** Members of nursing management, (Director of Nursing (DON), Resident Care Management Director (RCMD), Medical Records staff and MDS Coordinator audited physicians' orders and the lab section of the medical record of each resident beginning on 7/28/11 to assure that all ordered labs have been drawn and the results communicated to the attending physicians. The Medical Director reviewed the results of the audit on 7/29/11. On 7/29/11 the RCMD & MDS Coordinators reviewed the care plans and care cardexes of each resident to assure individualized interventions related to lab management (i.e. changes of condition, effectiveness of medications) are clearly identified and documented. On 7/31/11 the Regional Clinical Director (RCD), Interim DON, Charge Nurses & Medical Records Director reviewed the Lab Tickler Tool to validate that labs were transcribed to the Tool for the month of August as a part of the end of the month change over process.	

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F 157	Continued From page 2 documentation review, hospital record review, professional standards publications review, and interview the facility failed to notify the physician of an elevated potassium level and failed to immediately notify the physician of a subsequent critical potassium level for one resident (#5); the facility failed to notify the physician of lab results required for accurate dosing of medications for one resident (#12) receiving Vancomycin (anti-infective) intravenously, and one resident (#13) receiving total parenteral nutrition (TPN) feedings intravenously; and the facility failed to notify the physician timely of abnormal lab results for one resident (#14) with a low potassium level of nineteen residents reviewed. The facility's failure has caused or is likely to cause serious harm, injury impairment or death to residents #5, #12, #13, and #14. Resident #5 died as a result of an acute cardiac arrest with a critical potassium level of 8.4. The Administrator and the Regional Clinical Director were informed of the Immediate Jeopardy in the Conference Room on July 29, 2011, at 11:15 a.m. The findings included: Resident #5 was admitted to the facility on February 7, 2011, with diagnoses including Muscle Weakness, Atrial Fibrillation, Hypertension, Malignant Neoplasm of the Bladder with Metastasis, Acute Kidney Failure, Paralytic Ileus, Congestive Heart Failure, and status post Radical Cystoprostatectomy and Ileal Loop Diversion.	F 157	3. Systemic Changes The Medical Director reviewed the current lab management policy and process xwith the attending physicians on July 29, 2011. Orders received for residents who have orders for lab work are entered on the Lab Tickler Tool. The tool is to be completed by the licensed nurses at the time the lab order is received. The Charge Nurse is responsible to assure the lab provider is aware of the order and to assure that the lab is drawn timely. The Charge Nurses for 100, 200 & 300 hall will be responsible to check the lab portal on 3-11 shift by 7:00 pm and will print all lab results available and proceed to report any critical labs to the attending physician immediately. In the event an attending physician cannot be reached within 15 minutes of the critical result being received the nurse will contact Medical Director and DON.. Any abnormal labs will be reported to the attending physician within 24 hours of results being obtained by faxing to the MD's office. On weekends (Friday afternoon through Sunday) both abnormal & critical labs will be called to the MD. Documentation of this communication will be communicated to the physician by phone and will be notification will be documented on the lab and theas well as on the Lab Tickler tool. Abnormal & critical labs will be documented on the 24 hour report and will be communicated during shift to shift report so each nurse is aware of the lab result status.	

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F 157	Continued From page 3 Review of the resident's hospital lab results on January 6, 2011, through February 4, 2011, revealed the resident's potassium level fluctuated daily from a 3.3 L (low) level on January 9 and 29, 2011, to a critical high level of 6.1 on January 17, 2011, with the hospital's reference range for normal identified as 3.4 to 5.1 mmol (millimoles)/L (liter). Review of the hospital's discharge summary (discharged on February 7, 2011), dictated and transcribed on February 23, 2011, revealed, "...potassium level was repleted...sent to (facility name) for continued care, where they would continue ...nephrostomy tube care and urostomy tube care, with recording the output, ostomy care, physical therapy, and occupational therapy." Review of the Therapy Progress and Update notes from Occupational Therapy for the week of February 8 - 15, 2011, revealed, "...Pt (patient) with gains towards goals..." Review of the Therapy Progress Notes for Physical Therapy dated for the week of February 15 - 21, 2011, revealed, "...Pt (patient) has done very well over the past week of therapy...has met all STGS (short term goals) & (and) most LTGS (long term goals)..." Review of the facility's Interdisciplinary Plan of Care (POC), Need/Problem/Concern, dated February 18, 2011, revealed, "...Pot (potential) for abn. (abnormal) electrolytes AEB (as evidenced by)...(arrow pointing upward signifying increased) K+ (chemical symbol for potassium) level." Continued review of the Outcome/Goals section	F 157	Nurses on the 11-7 shift will perform a 24-hour medical record review to ensure that new orders have been properly transcribed, carried out, physicians notified of results and that each component is documented on the Lab Tickler Tool. In addition, the Interdisciplinary Team ("IDT"), which includes the Interim Director of Nursing, the Unit Manager, the Staff Development Coordinator, the Social Services Director, the Activities Director, the Registered Dietician, the MDS Coordinators, and the Rehab Program Manager. The IDT, reviews residents every morning Monday-Friday during the morning clinical stand up meeting. During the meeting the IDT reviews residents with new lab orders using the telephone order slips and the orders for newly admitted residents using the admission order sheets For new orders obtained or new admissions that occur on the weekends, the weekend RN supervisor will review and verify that the new lab orders were added to the Lab Tickler Tool and are reflected on the 24 hour report. A sample of five charts with new physician orders will be reviewed during the daily morning clinical meeting to determine whether the 24-hour chart check is occurring. This review will be done Monday-Friday for 30, days by the members of nursing management, which include the Interim DON, Unit Manager, SDC (Staff Development Coordinator) and RCMD (Resident Care Management Director). On the weekends these reviews will be completed by the weekend supervisor. If identified concerns are noted a 100% chart check will be completed by the members of nursing management and re-education will be completed with the nurse responsible by the Interim DON or Unit Manager.	

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F 157	Continued From page 4 of the POC, revealed, "Will have no s/s (signs and symptoms) of hyperkalemia (elevated potassium) thru 05/2011." Continued review of the Interventions/Approaches, revealed, "1) Monitor labs; 2) Meds (medications) as ordered; 3) Observe for leg cramps, chest pain, SOB (shortness of breath)." Review of the resident's Medication Administration Record (MAR) dated February 2011, revealed the resident was admitted with orders for Potassium Chloride 10 meq (milliequivalents) by mouth every day. Review of the Physician's Telephone Orders dated February 21, 2011, revealed, " (1) BMP (basic metabolic panel), CBC (complete blood count) today." Review of the lab results dated February 21, 2011, revealed a critical potassium level of 6.2 H! ("!" is the lab's designated symbol for identifying critical labs) with 3.6 - 5.4 mEq (milliequivalents) / (per) L (liter) used by the laboratory as the reference range for normal limits. Review of the Physician's Telephone Orders dated February 21, 2011, revealed, "Hold KCL (medication abbreviation for potassium chloride) tomorrow. Repeat KCL (lab) in AM (morning). Report to MD (medical doctor)." Review of the lab results dated February 22, 2011, revealed a critical potassium level of 6.4 H! Review of the Physician's Telephone Order dated February 22, 2011, revealed, "Kayexalate (potassium lowering medication) 15 g (grams) po (by mouth) x (times) 1 dose taken from ER	F 157	The IDT will validate that lab tests have been completed as ordered and follow-up is complete (physician and responsible party/resident notified) during afternoon clinical follow up meeting. Daily 3-11 charge nurses for 100, 200, 300 hall will pull lab results drawn that day by no later than 7pm. Abnormal labs will be communicated to the MD and resident and/or family member within 24 hours of the receipt of the results (This allows the nurse time to assess, document and make recommendations to the MD) Critical labs will be called to the facility by the lab and the nurse will immediately notify the MD within 15 minutes of receipt. If the attending physician does not respond within 15 minutes nurse will then notify Medical Director and Interim Director of Nursing.. Nurse will document that notification has occurred directly on the lab result form... The lab resultswill be filed in the medical record. In addition the charge nurse will update Lab Tickler Log to reflect the above.	

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F 157	Continued From page 5 (emergency) box. BMP (lab) in am." Review of the lab results dated February 23, 2011, revealed the potassium level was 5.4 (within normal range.) Review of the Physician's Telephone Orders dated February 23, 2011, revealed, "Hold KCL (potassium medication) Thurs (Thursday was 2/24/2011) & (and) Fri (Friday was 2/25/2011) Do BMP Fri (2/25/2011) & Mon (Monday was 2/28/2011) If KCL (potassium lab) remains within normal limits continue to hold KCL (medication)." Review of the Physician's Telephone Orders dated February 24, 2011, revealed, "BMP (lab) 2/24/11. D/C (discontinue) BMP on 2/25/2011 - redraw on 2/28/11 per order." Review of the lab results dated February 24, 2011, revealed the potassium level was 5.6 H (high). Medical record review of the same lab report and nurses notes revealed no documentation the physician had been notified of the abnormal lab. Review of the lab results dated February 28, 2011, revealed the potassium level was 5.6 H. Continued review of the lab result revealed the Nurse Practitioner initialed the lab result without the date or time the result had been reviewed. Interview with Licensed Practical Nurse (LPN) #8 on July 28, 2011, at 8:40 a.m., confirmed the Nurse Practitioner (NP) made rounds on March 2, 2011, and reviewed the labs from February 28, 2011. Continued interview confirmed the NP ordered the BMP to be completed the next day.	F 157	The Lab Tickler Tool will be initiated at the end of the month during the changeover process to reflect labs due for the upcoming month. The Interim Director of Nursing or designee and the Region Clinical Director will receive documentation of potential new admissions with orders for IV antibiotic therapy prior to admission to review medications and the method of administration. The Interim Director of Nursing and Region Clinical Director will jointly determine whether the facility has the resources to accept the referral. This joint review will continue for 60 days. The IDT team will review the orders of residents admitted with Vancomycin antibiotic therapy and TPN during the morning meeting to assure that orders are transcribed properly and that orders are noted on the Lab Tickler Tool in accordance with the facility's lab process. Such review will continue for 60 days or until the IDT determines that the process is in place and working effectively through the QA and A process. On 7/27/11 the Region Clinical Director (RCD) and the Interim Director of Nursing initiated education for licensed nurses, certified nursing assistants, dietary staff and the registered dietician regarding the lab management system and the use of the Lab Tickler and Lab Audit Tools. Licensed nurses were educated by DON/SDC and RCD. Education began on July 28, 2011 regarding the Lab Process to include monitoring of Vancomycin levels and monitoring of labs associated with TPN administration. The education process will continue until licensed staff has been education. Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the the new hire orientation process.	

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F 157	Continued From page 6 Telephone interview with the NP on August 1, 2011, at 11:10 a.m., from the conference room confirmed, "It is possible I reviewed the labs from February 28, 2011, and ordered the BMP on March 2, 2011, during my rounds." Review of the Physician's Telephone Order dated March 2, 2011, revealed, "BMP in AM." Review of the resident's lab result dated March 3, 2011, revealed the potassium level was 6.0 H (high). Medical record review revealed no documentation the physician had been notified of the abnormal lab result on March 3, 2011. Continued review revealed the abnormal lab result had been faxed to the physician's office on March 7, 2011, (four days from the day the facility received the results). Interview with Registered Nurse (RN) #3 on July 26, 2011, at 2:15 p.m., in the conference room confirmed the RN found the abnormal lab result (potassium 6.0 H) dated March 3, 2011, "on the desk" on March 7, 2011, and faxed the result to the physician's office because RN #3 did not know if the physician had been made aware of the abnormal results. Interview with the resident's attending physician via telephone conversation on July 27, 2011, at 10:00 a.m., revealed the physician denied receiving the lab results. Continued interview confirmed the following interventions would have been in order had the physician received the elevated potassium results on March 3, 2011, of 6.0 H (high). 1) Review the resident's	F 157	The Interim Director of Nursing and/or designee initiated the process of educating licensed nurses on 8/2/11 regarding the proper method of administering Vancomycin and the importance of assuring appropriate monitoring of Vancomycin levels through lab results. Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the the new hire orientation process. The Interim Director of Nursing and/or designee initiated the process of educating licensed nurses on 8/2/11 regarding the proper method of administering TPN and the importance of assuring appropriate monitoring of labs associated with TPN administration. Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the the new hire orientation process.	

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F 157	Continued From page 7 medications to ensure potassium was not being given; 2) Talk to the nurses; 3) Review the resident's diet and assessed hydration status; 4) Force fluids if needed; 5) Probably give oral Kayexalate (medication to reduce potassium levels in the blood stream). Telephone interview with the resident's attending physician on July 27, 2011, at 1:30 p.m., confirmed the physician's office had no record of any faxed notification of the abnormal potassium (6.0 H) lab result for March 3, 2011. Telephone interview on July 28, 2011, at 10:47 a.m., with the physician on-call March 3, 2011, denied knowledge of notification of the abnormal potassium level, but confirmed had the physician received notification of the abnormal potassium level of 6.0 H on March 3, 2011, the physician would have ordered treatment, "repeated the lab, maybe done an electrocardiogram (EKG), Calcium level, and sent to emergency room (ER)." Medical record review revealed no new physician's orders had been received as a result of the high potassium lab dated March 3, 2011. Review of the Nursing Daily Skilled Summary (nurse's note) dated March 8, 2011, at 10:00 a.m., revealed the resident complained of nausea and vomiting. Continued review of the narrative note from Licensed Practical Nurse (LPN) #8 revealed, "Rec'd (received) orders...to get CBC (complete blood count), CMP, UA (urinalysis) C&S (culture and sensitivity), and Zofran (an anti-emetic for nausea and vomiting) 4 mg (milligrams) po (by mouth) q (every) 6 hr (hours)	F 157	Licensed Nurses were educated on the 24-hour chart check process by the Staff Development Coordinator (SDC), which began on 8/2/11. Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the the new hire orientation process. Nursing management and other clinical resources began the process of clinical competency testing of licensed nurses on administration of IVs, TPN, Trach care, etc. WHEN Nurses will be required to demonstrate competencies prior to being permitted to resume floor responsibilities. Nurses will not be permitted to resume regular work duties until competency testing is completed. Competency testing will be incorporated into the the new hire orientation process. Licensed nurses will be educated by the Interim DON/designee regarding their responsibilities to assure labs are drawn timely. The licensed nurses are to obtain the blood sample in the event that the lab phlebotomist is unavailable in order to obtain the specimen timely. This will allow the facility to assure that the medication is administered according to physicians' orders Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the the new hire orientation process.	

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F 157	Continued From page 8 prn (as needed) N/V (nausea and vomiting)." Review of the lab results dated March 8, 2011, revealed the resident had a critical potassium level of 8.4 H! (The exclamation point signified a critical level per telephone interview with the Lab Manager on July 27, 2011, at 10:25 a.m.) Continued review of the March 8, 2011, lab result revealed the lab representative informed Registered Nurse (RN) #2 of the critical potassium level at 5:57 p.m. Review of the Nursing Daily Skilled Summary dated March 8, 2011, 6:00 p.m., revealed RN #2 received the critical lab information from the lab, and reported the critical lab result to RN #3. Review of the Nursing Daily Skilled Summary dated March 8, 2011, revealed RN #3 attempted to notify the physician through the physician's answering service at 7:00 p.m. Continued review of the nurse's note revealed the physician did not return the call until 7:45 p.m. Continued review revealed the physician ordered the resident to be sent to the emergency room for evaluation. Review of the physician's answering service call log dated March 8, 2011, revealed the physician on-call service did not receive the call until 7:50 p.m., with the message, "(resident name) very pail (pale) & (and) sick @ (at) stomach w/t (with) pain pls (please) call." Review of the nurse's note written by RN #3 dated March 8, 2011, revealed the emergency services transport had been called at 8:10 p.m. Review of the emergency services transport	F 157	Charge nurse for 100, 200 & 300 hall are responsible to report abnormal Vancomycin levels to the MD on the same day results of receipt for appropriate dosing by MD of next dose. MD notification should be documented directly on the lab results. The lab results should then filed in the Medical Record. Charge nurse for 100, 200 & 300 hall are responsible to report lab results for residents receiving TPN to the Pharmacy for recommendations of TPN dosing. Once dosing recommendations are received the Charge Nurse is to communicate recommendations to the MD that same day for the next day's TPN dosing instruction. MD notification should be documented directly on the lab results. The lab results should then filed in the Medical Record. The Division Director of Pharmacy Services has contacted the Consultant Pharmacist to remind him/her about his/her responsibility to review, during monthly visits, the use and possible discontinuation of Vancomycin antibiotic therapy.	

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F 157	Continued From page 9 record revealed the call from the facility was received at 8:37 p.m. Continued review revealed emergency services (EMS) were at the facility at 8:50 p.m.; departed the facility at 9:14 p.m., and arrived at the emergency room (ER) at 9:17 p.m. Interview with RN #2 in the conference room on July 26, 2011, at 1:30 p.m., confirmed RN #2 had received the call from the laboratory at 6:00 p.m., with the critical lab result for resident #5. Continued interview confirmed RN #2 relayed the information verbally to RN #3, and solicited a response from RN #3 regarding understanding of information relayed. Continued interview with RN #2 confirmed RN #3 responded affirmatively. Interview with RN #3 in the conference room on July 26, 2011, at 2:15 p.m., confirmed the RN could not recall treatments, resident symptoms, or interventions provided for the resident during the length of time from 6:00 p.m. until 7:50 p.m., to call the physician's answering service; and from 7:50 p.m. to 8:37 p.m., to call the ambulance service. Telephone interview with Certified Nurse Aide (CNA) #5 on August 1, 2011, at 12:07 p.m., confirmed the CNA worked second shift (3 p.m. to 11:00 p.m.) had been assigned to care for resident #5 on March 8, 2011. Continued interview confirmed the resident was "okay" at 2:30 p.m. (beginning of shift). Continued interview confirmed the resident had complained about not feeling good around 4:00 p.m. Review of the Nursing Daily Skilled Summary written by RN #3, dated March 8, 2011, at 8:10 p.m., revealed, "...Call placed to ambulance. Pt	F 157	4. Quality Assessment and Assurance Committee The Quality Assessment and Assurance Committee will meet weekly for a month and monthly thereafter to discuss compliance with this plan and to review identified trends and patterns regarding the lab management system. The Committee includes the Medical Director, Administrator, DON, pharmacist, members of the IDT and at least one member of direct care staff. • Lab issue was identified on 5/11/11 during Quality Review Process: • Action plan was developed along with step-by-step lab process to address the lab system. It was brought to the May 18th QAA meeting as a identified concern/focus with action in process: • All licensed staff were educated on Lab Process and this education was completed by 6/8/11. • June QAA meeting held 6/14/11 also reflect action in progress related to the Lab process	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 10 (patient) given a PRN (as needed) pain med (medication) for C/O (complains of) pain to lower ABD (abdomen) rated @ (at) 5 on a scale of 1-10..." Continued review revealed, "...8:50 p.m. ambulance here to pick up and transport to hospital..." Medical record review of the Medication Administration Record dated March 2011, revealed the resident had orders for "...Hydrocodone/Acetaminophen (narcotic pain medication) 5 mg - 325 mg, Take 1 tablet by mouth every 4 hours as needed for pain..." Medical record review of the Medication Administration Record dated March 2011, and the narcotics tracking log revealed no documentation the resident received the medication on March 8, 2011. Medical record review revealed no documentation of the transfer assessment or vital signs provided to the emergency medical services transport. Review of the emergency transport services report dated March 8, 2011, revealed, "...The call came in as critical labs. After arriving on the scene...called for assistance on a working code (A code is the term used to define resuscitative measures performed in the absence of breath and/or pulse)..." Review of the emergency room Initial Assessment Form dated March 8, 2011, at 9:15 p.m., revealed, "...Cardiac arrest pre-hospital..." Continued review revealed the resident presented to the ER with CPR (cardiopulmonary resuscitation) in progress. Review of the hospital Code Blue Flow Sheet dated March 8, 2011, at	F 157	The Region Clinical Director will review the minutes of the Committee meetings weekly for one month and then quarterly thereafter to assure that appropriate discussion and follow-up is documented. Alleged Date of Compliance: August 16, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

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F 157	Continued From page 11 9:21 p.m., revealed, "...Type of Arrest...Cardiopulmonary, Hyperkalemia; Patient Diagnosis: Hyperkalemia, Ca (Cancer)..." Continued review revealed the time the code ended was 9:35 p.m. Review of the resident's death certificate revealed the cause of death was Acute Cardiac Arrest and Carcinoma of Bladder. Review of professional literature on potassium imbalance from the Diseases and Disorders Handbook, revealed, "...Because serum potassium level has such a narrow normal range (3.5 - 5 mEq/liter), a slight deviation in either direction can produce profound clinical consequences. Paradoxically, both hypokalemia (potassium deficiency) and hyperkalemia (potassium excess) can lead to muscle weakness and flaccid paralysis...Both conditions also diminish excitability and conduction rate of the heart muscle, which may lead to cardiac arrest..." Continued review revealed clinical features of potassium imbalance include nausea, diarrhea, and abdominal cramps. Review of the facility's policy, Laboratory Management, revealed, "...If the results of the lab tests are Abnormal or Critical Values, the attending Physician/Licensed Provider will be notified immediately at the time the results are received. Date, time, and person notified should be documented on the lab report and signed by the Licensed Nurse...If a resident's primary care Physician/Licensed Provider (or their on-call coverage) cannot be reached to report a critical or abnormal value, the facility Medical Director or the Medical Director's NP (Nurse Practitioner)/designee and the DON (Director of Nursing)/designee will be contacted with the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

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F 157	Continued From page 12 results." Telephone interview with the resident's attending physician on July 27, 2011, at 1:30 p.m., confirmed the potassium level of 8.4 H! (critical) would have required emergency treatment. Interview with the Director of Nursing on July 27, 2011, at 11:20 a.m., in the conference room confirmed the facility's policy for reporting abnormal and critical lab values had not been followed. Continued interview confirmed the documentation was unclear as to why the resident had not been treated sooner. In summary, resident #5 was admitted to the facility status post surgery, and with fluctuating lab values, specifically K+ (potassium), a critical element in the physiology of the rhythm of the heart. The resident was admitted for rehabilitation with the goal of returning home upon discharge. Lab results obtained on February 24 and 28, 2011, and March 3, 2011, indicated elevated and abnormal K+ levels for which physician notification on those dates cannot be verified. When the resident complained of nausea, vomiting, and abdominal pain (all indicators of elevated potassium) on March 8, 2011, new labs were ordered, and the critical potassium level of 8.4 was revealed. From the time the lab reported the critical K+ level to the facility at 5:57 p.m., on March 8, 2011, until the ambulance arrived at 8:50 p.m., 2 hours and 53 minutes of time elapsed resulting in a delay in treatment. RN #3 stated the physician was notified as soon as he/she had been informed of the lab (around 6:00 p.m.) The physician's answering service call log indicated	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

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F 157	Continued From page 13	F 157		

the call was not received until 7:50 p.m. (1 hour, 50 minutes) later. RN #3 stated the emergency transport services had been notified at 8:10 p.m. The emergency services transport services log indicated the call was received at 8:37 p.m. The failure of facility staff to follow the facility policy in notifying the physician and calling for emergency services resulted in the delay of treatment. Subsequently, as the resident was being loaded into the emergency transport, vital signs ceased, and resuscitation measures began. Review of the Emergency Room records revealed resuscitation continued in the ER, without success. The resident died of Acute Cardiac Arrest at 9:35 p.m., on March 8, 2011.

Resident #12 was admitted to the facility on February 15, 2011, with diagnoses including Osteomyelitis (inflammation of the bone), Diabetes Mellitus, End Stage Renal Disease, Peripheral Vascular Disease, Hypertension, Backache, and Sepsis/Bacteremia (bacteria in the blood).

Review of the Admission Orders dated February 15, 2011, signed by the attending physician, revealed, "...Vancomycin 1000 mg (milligrams) IV (intravenous) once daily..." Continued review revealed, "...peak & (and) trough q (every) 3rd (third) dose. Pharmacy to dose..." Review of the resident's Medication Administration Record dated February 2011, revealed the resident received Vancomycin (an anti-infective used for serious or severe infections) 1000 mg (milligrams) intravaneously once daily.

Review of the facility's policy, Blood Sampling for Peak and Trough Values, revealed, "1. The peak

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 14 is a measurement of drug in the blood after it has been given and at its highest level of concentration. Ideally 30-60 minutes following infusion. 2. The trough is a measurement of drug in the blood right before the next dose and at its lowest level of concentration in the blood. Ideally just prior to infusion...4. The ACTUAL TIME a specimen is obtained and the ACTUAL TIME the dose was hung is CRITICAL to accurately interpret drug levels for dosing considerations..." Review of the lab record dated February 18, 2011, and identified by the lab as "Trough" revealed a critical result of 37.1 H! (H! indicates a critical lab value) with a reference range of 10.0 - 20.0. Continued review revealed the Medical Director had initialed the lab report and written "Stopped Vancomycin" with no time or date. Review of the Physician's Orders from February 15, through February 24, 2011, revealed no order to discontinue the Vancomycin. On February 24, 2011, the resident was readmitted to the hospital for acute exacerbation of chronic lower back pain. Review of the Medication Administration Record dated February 2011, and interview with Licensed Practical Nurse (LPN) #6 on August 2, 2011, at 7:30 a.m., in the conference room, confirmed the resident received daily doses of Vancomycin for February 15 - 24, 2011. Review of the Nursing 2010 Drug Handbook, revealed adverse reactions of Vancomycin include fever, pain, hypotension, pseudomembranous colitis, nausea, nephrotoxicity, and anaphylaxis. Continued	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 15	F 157		

review revealed, "...Patients with renal dysfunction need dosage adjustment. Monitor blood levels to adjust I.V. (intravenous) dosage. Normal therapeutic levels of Vancomycin are peak, 30 to 40 mg (milligrams)/L (liter) (drawn 1 hour after infusion ends), and trough, 5 to 10 mg/L (drawn just before next dose is given).

Interview with the Medical Director on August 1, 2011, at 1:15 p.m., by telephone from the conference room confirmed, "Was not aware the resident continued to receive the medication...Someone told me it had been stopped...I was not the patient's primary physician, but I pay attention to the labs...We have a kink in notification, signing what has been done...You know what they say, not documented, not done...That is a problem..."

In summary, the facility continued to administer an anti-infective (Vancomycin) for 6 days after the critical lab value was received.

Resident #13 was admitted to the facility on April 12, 2011, and readmitted on May 4, 2011, with diagnoses including Aspiration Pneumonia, Acute Renal Failure with Kidney Disease, Hypokalemia, Severe Volume Depletion, Malabsorption Syndrome, and Hyponatremia.

Medical record review of the TPN (Total Parenteral Nutrition)/PPN (Peripheral Parenteral Nutrition) Order Form, revealed the resident was admitted with "Custom Formula (specific ingredients, measured additives)" orders for TPN on May 4, 2011. Review of the Admission Orders dated May 4, 2011, revealed the lab tests for "CMP (Complete Metabolic Panel); Mag

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 16 (Magnesium); CBC (Complete Blood Count) q (every) 3 days." The definition of TPN provided by Taber's Cyclopedic Medical Dictionary is as follows: Provision of the total caloric needs by intravenous route for a patient who is unable to take food orally. Review of the Handbook for Geriatric Nursing Care revealed TPN is the parenteral administration of dextrose, proteins, electrolytes, vitamins, and trace elements in amounts that exceed the patient's energy expenditure and thereby achieve anabolism (The building up of the body substance). Review of the Dietary Progress Notes dated May 5, 2011, revealed, "...TPN to meet nutritional needs secondary to malabsorption syndrome...CMP/Mag(magnesium)/CBC q 3 days & communicate to MD (Medical Doctor) who will be managing TPN." Review of the laboratory results from May 4, through May 13, 2011, revealed no labs had been completed on May 7, 2011, the first day the labs were due since the resident's admission on May 4, 2011. Review of the resident's lab results dated May 10, 2011, revealed the following abnormal lab values: Blood Urea Nitrogen (normal: 8-24) 52 H (H= high); Creatinine (normal: .5-1.1) 1.2 H; BUN/Creatinine Clearance (normal: 6.0-25.0) 43.7 H; Glomerular Filtration Rate (normal: greater than 60) 55 L (L= low); Chloride (normal: 97-112) 91 L; CO2 (normal: 20-32) 35 H; Calcium (normal:8.7-10.4) 8.5 L; Total Protein (normal 6.2-8.0) 5.9 L; Albumin (normal: 3.2-5.0) 3.0 L;	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 17	F 157		

Alkaline Phosphate (normal: 35-105) 145 H; Red Blood Cells (normal: 3.8-5.0) 3.09 L; Hemoglobin (normal: 11.5-15.5) 9.0 L; Hematocrit (normal: 36-45) 27.5 L ...Continued review revealed no documentation the physician had been notified of the abnormal labs. Continued review revealed no changes in the TPN formula order.

Review of the resident's lab results dated May 13, 2011, revealed the following abnormal lab values: Blood Urea Nitrogen (normal: 8-24) 45 H; Creatinine (normal: .5-1.1) 1.4 H; BUN/Creatinine Clearance (normal: 6.0-25.0) 32.2 H; Glomerular Filtration Rate (normal: greater than 60) 46 L; Chloride (normal: 97-112) 93 L; CO2 (normal: 20-32) 34 H; Calcium (normal:8.7-10.4) 8.3 L; Total Protein (normal 6.2-8.0) 5.3 L; Albumin (normal: 3.2-5.0) 2.6 L; Alkaline Phosphate (normal: 35-105) 163 H; PreAlbumin (normal: 17-34) 13.1 L; Glucose (normal: 73-107) 169 H ...Continued review revealed no documentation the physician had been notified. Continued review revealed no changes in the TPN formula order.

Review of the facility's policy, Total Parenteral Nutrition Checklist, revealed, "...monitor labs frequently per physician's order and notify physician of any lab abnormalities or sudden changes. TPN formula may need to be adjusted..."

Telephone interview with the Pharmacy Representative on August 2, 2011, at 10:55 a.m., in the conference room confirmed residents come from the hospital or home with initial TPN orders. The TPN orders are transcribed to the TPN standardized form (TPN/PPN Order Form), and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 18 sent to the physician for approval before the TPN formula is sent to the facility. Continued interview confirmed the pharmacy maintains care plans for each TPN resident, contacts the facility for order changes, and any formula changes made are a result of the physician's orders. Continued interview confirmed the initial formula is prepared from the TPN/PPN Order Form and subsequent formulas are based on labs (electrolytes, CBC, blood sugars) monitored by the Physician. Continued interview confirmed any changes in the TPN formula must come from the Physician. Telephone interview with the Pharmacy Representative on August 2, 2011, at 12:45 p.m., confirmed the pharmacy had no copies of labs in resident #13's care plan. Continued interview confirmed according to the pharmacy's care plan, the IV (Intravenous) Technician called the facility every other day, spoke with the nurse in charge of the resident, and inquired of physician changes to the orders for TPN. Continued interview confirmed no changes to the TPN orders had been communicated by the nurses to the pharmacy during the resident's stay in the facility. Interview with the Regional Clinical Director (RCD) #1 on July 29, 2011, at 3:00 p.m., in the conference room, confirmed there was no record of lab tests completed on May 7, 2011, as ordered by the physician. Telephone interview with the Medical Director on August 1, 2011, at 2:45 p.m., confirmed the resident had been admitted from the hospital on TPN. Continued interview confirmed the facility was responsible for obtaining the resident's labs and reporting the results to the physician to	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 19	F 157		

ensure the appropriate TPN formula. Continued interview confirmed the Physician's understanding was the facility faxed the lab results to the Pharmacy; the Pharmacy made recommendations based on the lab results for changes in the TPN formula; and the Physician approved the changes. Continued interview confirmed the physician was not aware the Pharmacy had not reviewed the lab results. Continued interview confirmed, "...No system is perfect...work toward effectiveness...learn from these mistakes...educate constantly..."

Interview with RCD #1 and RCD #2 in the conference room on August 2, 2011, at 9:15 a.m., confirmed the TPN formula had not been changed as a result of the abnormal lab results at any time during the resident's stay. Interview with the Registered Dietician (RD) in the conference room on August 2, 2011, at 9:25 a.m., with RCD #1 and #2 present, confirmed the RD was not responsible for the TPN formula.

In summary, the resident #13 was admitted with TPN orders, approved and signed by the physician. The physician ordered labs on admission to monitor the resident's needs regarding the TPN formula. The physician stated the pharmacy monitored the labs and would have made recommendations for changes. The pharmacy stated the physician monitored the labs and made changes. The May 7, 2011, lab had not been completed as ordered. There was no documentation the physician was notified for abnormal lab results for lab obtained on May 10 and May 13, 2011. Prior to formulating and dispensing TPN formula, the pharmacy records indicated a pharmacy representative contacted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 20	F 157		

facility nurses to check for changes in the physicians orders. According the Pharmacy Representative, no changes were made to the TPN formula during the resident's stay at the facility. The resident was discharged to the emergency room on May 15, 2011, with complaints of shortness of breath and increased anxiety.

Resident #14 was admitted to the facility on May 12, 2011, with diagnoses including Metastatic Prostate Cancer, T11 (Thoracic vertebrae #11) Compression Fractures with Cord Compression, Hypovolemia, and Hyponatremia.

Review of the Physician's Orders dated May 27, 2011, revealed an order for a CMP (Comprehensive Metabolic Panel) lab test to be completed on May 31, 2011.

Review of the lab results dated May 31, 2011, revealed the resident had abnormal lab values specifically a low potassium level of 3.4 with 3.6 - 5.4 identified as the normal range. Continued review revealed a notation on the bottom of the lab sheet, "...results called to Dr (doctor)..." and signed by the Licensed Practical Nurse (LPN). Continued review revealed an order, "40 meq (milliequivalents) po (by mouth) Potassium Chloride x (times) 1 now..."

Review of the Handbook of Geriatric Nursing Care, revealed, "...Potassium imbalances may result in such complications as muscle weakness and flaccid paralysis, and may also lead to cardiac arrest..."

Review of the Physician's Order dated June 3,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 21 2011, revealed, "1. Give Potassium Chloride 40 meq (milliequivalents) 1 po (by mouth) now..." Interview with the LPN #1 on August 1, 2011, at 9:05 a.m., in the conference room, confirmed the physician had not been notified of the May 31, 2011, lab result until June 3, 2011. In summary, the facility failed to notify the Physician timely of abnormal lab results received on May 31, 2011, and not reported until June 3, 2011, resulting in a 3 day delay in treatment for the resident. The Immediate Jeopardy was effective from March 3, 2011, through August 3, 2011, and was removed August 3, 2011. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the survey team through review of facility documents, staff interviews, and observations conducted onsite on August 3, 2011. The survey team verified the allegation of compliance by: 1.) Reviewing the facility's plan for ensuring physician orders for lab work are processed and tracked to ensure the physician is notified of the results in a timely manner. Reviewing the facility's plan for auditing records to ensure staff are following the plan. Reviewing the facility's in-service records to ensure nursing staff have been or will be educated before resuming work regarding changes to and implementation of the facility's policy for processing, tracking, reporting, and monitoring labs. The Director of Nursing (DON) on site at the beginning of the survey	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 22 resigned on July 29, 2011, and an interim DON had been appointed on August 1, 2011. 2.) Conducting interviews with 9 of 21 nurses on staff to determine the level of comprehension gained through in-service education conducted regarding the changes to the facility policy for ordering, receiving, reporting, and tracking lab results including the use of the Lab Tickler Tool for monitoring to ensure all labs are completed and reported timely. Continued interviews to confirm nurses were knowledgeable of the facility's process for reporting critical and abnormal labs to the physicians; knowledgeable of how to reach physician's after hours, and the time to wait for a call back from the physician; knowledgeable of who to contact if the physician cannot be reached or does not return the call timely. 3.) Reviewing additional charts for 3 of 4 residents currently receiving Vancomycin to ensure the medication is being administered according to the facility's policy and physician's orders; to ensure lab orders for peak and trough were documented on the Lab Tickler Tool for tracking. Interviewing nursing staff to ensure comprehension of the importance of the peak and trough labs, when each should be drawn, and who should draw the labs. Interviewing staff to ensure comprehension of the importance of administering the medication on a strict schedule and notifying the physician if unable to adhere to that schedule. Verifying resident careplans and cardexes included individualized interventions related to lab management.	F 157		

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F 157	Continued From page 23 4.) Reviewing additional charts for 1 out of 1 resident currently receiving TPN to assure the TPN is being administered according to facility policy and physician's orders; reviewing the new guidelines for dosing TPN which assigns the responsibility for notifying the pharmacy of the resident's lab results on the charge nurses assigned to each hall. Once dosing recommendations are received from the pharmacy, the charge nurse is responsible to communicate the pharmacy's recommendations to the physician and physician notification will be documented on the lab results. In addition the Lab Tickler Tool will be updated to reflect notification and charting results. Verifying residents receiving TPN included labs ordered by the physician had been completed, and the results communicated to the attending physicians. Verifying resident careplans and cardexes included individualized interventions related to lab management. 5.) Reviewing 1 resident chart from random selection to ensure the critical lab result obtained from the pharmacy on August 3, 2011, was processed according to the amended facility policy for lab management. 6.) Reviewing the Addendum to the facility policy, Laboratory Management, regarding the timeliness of physician notification for abnormal and critical labs including specifics regarding the time to wait for a return call, and what to do if the physician does not return the call. Non-compliance continues at a "E" level for monitoring corrective actions. The facility is required to submit a plan of correction.	F 157		

AUG 22 2011

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F 157	Continued From page 24	F 157		
F 309 SS=K	TN00027877 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the physician's on-call answering service log, emergency medical services documentation review, hospital record review, facility policy review, professional standards publications review, and interview, the facility failed to monitor and provide treatment for abnormal lab values specifically potassium (K+) which subsequently resulted in a critical lab value requiring emergent care for one resident (#5); the facility failed to provide emergent care in a timely manner for one resident (#5); the facility failed to follow physician's orders for monitoring lab results and notifying the physician for accurate dosing of	F 309		

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F 309	Continued From page 25 medications and total parenteral nutrition (TPN) feedings for three residents (#12, #13, #14); and the facility failed to follow facility policy for reporting critical and abnormal lab values for four residents (#5, #12, #13, #14) of nineteen residents reviewed. The facility's failure has caused or is likely to cause serious harm, injury, impairment or death to residents #5, #12, #13, and #14. Resident #5 died as a result of an acute cardiac arrest with a critical potassium level of 8.4. The Administrator and the Regional Clinical Director were informed of the Immediate Jeopardy in the Conference Room on July 29, 2011, at 11:15 a.m. F309 resulted in Substandard Quality of Care. The findings included: Resident #5 was admitted to the facility on February 7, 2011, with diagnoses including Muscle Weakness, Atrial Fibrillation, Hypertension, Malignant Neoplasm of the Bladder with Metastasis, Acute Kidney Failure, Paralytic Ileus, Congestive Heart Failure, and status post Radical Cystoprostatectomy and Ileal Loop Diversion. Review of the resident's hospital lab results on January 6, 2011, through February 4, 2011, revealed the resident's potassium level fluctuated daily from a 3.3 L (low) level on January 9 and 29, 2011, to a critical high level of 6.1 on January 17, 2011, with the hospital's reference range for normal identified as 3.4 to 5.1 mmol (millimoles)/L (liter).	F 309	F309 **1. Residents identified to be affected by the alleged deficient practice.** The four residents identified to have been affected by the alleged deficient practice, #5, #12, #13 and #14, are no longer at the facility; therefore, no further action can be taken for these residents. **2. Residents who have the potential to be affected by the alleged deficient practice.** Members of nursing management, (Director of Nursing (DON), Resident Care Management Director (RCMD), Medical Records staff and MDS Coordinator audited physicians' orders and the lab section of the medical record of each resident beginning on 7/28/11 to assure that all ordered labs have been drawn and the results communicated to the attending physicians. The Medical Director reviewed the results of the audit on 7/29/11. On 7/29/11 the RCMD & MDS Coordinators reviewed the care plans and care cardexes of each resident to assure individualized interventions related to lab management (i.e. changes of condition, effectiveness of medications) are clearly identified and documented. On 7/31/11 the Regional Clinical Director (RCD), Interim DON, Charge Nurses & Medical Records Director reviewed the Lab Tickler Tool to validate that labs were transcribed to the Tool for the month of August as a part of the end of the month change over process.	

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F 309	Continued From page 26 Review of the hospital's discharge summary (discharged on February 7, 2011), dictated and transcribed on February 23, 2011, revealed, "...potassium level was repleted...sent to (facility name) for continued care, where they would continue ...nephrostomy tube care and urostomy tube care, with recording the output, ostomy care, physical therapy, and occupational therapy." Review of the Therapy Progress and Update notes from Occupational Therapy for the week of February 8 - 15, 2011, revealed, "...Pt (patient) with gains towards goals..." Review of the Therapy Progress Notes for Physical Therapy dated for the week of February 15 - 21, 2011, revealed, "...Pt (patient) has done very well over the past week of therapy...has met all STGS (short term goals) & (and) most LTGS (long term goals)..." Review of the facility's Interdisciplinary Plan of Care (POC), Need/Problem/Concern, dated February 18, 2011, revealed, "...Pot (potential) for abn. (abnormal) electrolytes AEB (as evidenced by)...(arrow pointing upward signifying increased) K+ (chemical symbol for potassium) level." Continued review of the Outcome/Goals section of the POC, revealed, "Will have no s/s (signs and symptoms) of hyperkalemia (elevated potassium) thru 05/2011." Continued review of the Interventions/Approaches, revealed, "1) Monitor labs; 2) Meds (medications) as ordered; 3) Observe for leg cramps, chest pain, SOB (shortness of breath)." Review of the resident's Medication	F 309	3. Systemic Changes The Medical Director reviewed the current lab management policy and process xwith the attending physicians on July 29, 2011. Orders received for residents who have orders for lab work are entered on the Lab Tickler Tool. The tool is to be completed by the licensed nurses at the time the lab order is received. The Charge Nurse is responsible to assure the lab provider is aware of the order and to assure that the lab is drawn timely. The Charge Nurses for 100, 200 & 300 hall will be responsible to check the lab portal on 3-11 shift by 7:00 pm and will print all lab results available and proceed to report any critical labs to the attending physician immediately. In the event an attending physician cannot be reached within 15 minutes of the critical result being received the nurse will contact Medical Director and DON.. Any abnormal labs will be reported to the attending physician within 24 hours of results being obtained by faxing to the MD's office. On weekends (Friday afternoon through Sunday) both abnormal & critical labs will be called to the MD. Documentation of this communication will be communicated to the physician by phone and will be notification will be documented on the lab and as welll as on the Lab Tickler tool. Abnormal & critical labs will be documented on the 24 hour report and will be communicated during shift to shift report so each nurse is aware of the lab result status.	

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F 309	Continued From page 27 Administration Record (MAR) dated February 2011, revealed the resident was admitted with orders for Potassium Chloride 10 meq (milliequivalents) by mouth every day. Review of the Physician's Telephone Orders dated February 21, 2011, revealed, " (1) BMP (basic metabolic panel), CBC (complete blood count) today." Review of the lab results dated February 21, 2011, revealed a critical potassium level of 6.2 H! ("!" is the lab's symbol for identifying critical labs) with 3.6 - 5.4 mEq (milliequivalents) / (per) L (liter) used by the laboratory as the reference range for normal limits. Review of the Physician's Telephone Orders dated February 21, 2011, revealed, "Hold KCL (medication abbreviation for potassium chloride) tomorrow. Repeat KCL (lab) in AM (morning). Report to MD (medical doctor)." Review of the lab results dated February 22, 2011, revealed a critical potassium level of 6.4 H! Review of the Physician's Telephone Order dated February 22, 2011, revealed, "Kayexalate (potassium lowering medication) 15 g (grams) po (by mouth) x (times) 1 dose taken from ER (emergency) box. BMP (lab) in am." Review of the lab results dated February 23, 2011, revealed the potassium level was 5.4 (within normal range.) Review of the Physician's Telephone Orders dated February 23, 2011, revealed, "Hold KCL (potassium medication) Thurs (Thursday was 2/24/2011) & (and) Fri (Friday was 2/25/2011) Do BMP Fri (2/25/2011)	F 309	Nurses on the 11-7 shift will perform a 24-hour medical record review to ensure that new orders have been properly transcribed, carried out, physicians notified of results and that each component is documented on the Lab Tickler Tool. In addition, the Interdisciplinary Team ("IDT"), which includes the Interim Director of Nursing, the Unit Manager, the Staff Development Coordinator, the Social Services Director, the Activities Director, the Registered Dietician, the MDS Coordinators, and the Rehab Program Manager. The IDT, reviews residents every morning Monday-Friday during the morning clinical stand up meeting. During the meeting the IDT reviews residents with new lab orders using the telephone order slips and the orders for newly admitted residents using the admission order sheets For new orders obtained or new admissions that occur on the weekends, the weekend RN supervisor will review and verify that the new lab orders were added to the Lab Tickler Tool and are reflected on the 24 hour report. A sample of five charts with new physician orders will be reviewed during the daily morning clinical meeting to determine whether the 24-hour chart check is occurring. This review will be done Monday-Friday for 30, days by the members of nursing management, which include the Interim DON, Unit Manager, SDC (Staff Development Coordinator) and RCMD (Resident Care Management Director). On the weekends these reviews will be completed by the weekend supervisor. If identified concerns are noted a 100% chart check will be completed by the members of nursing management and re-education will be completed with the nurse responsible by the Interim DON or Unit Manager.	

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F 309	Continued From page 28 & Mon (Monday was 2/28/2011) If KCL (potassium lab) remains within normal limits continue to hold KCL (medication)." Review of the Physician's Telephone Orders dated February 24, 2011, revealed, "BMP (lab) 2/24/11. D/C (discontinue) BMP on 2/25/2011 - redraw on 2/28/11 per order." Review of the lab results dated February 24, 2011, revealed the potassium level was 5.6 H (high). Medical record review of the same lab report and nurses notes revealed no documentation the physician had been notified of the abnormal lab. Review of the lab results dated February 28, 2011, revealed the potassium level was 5.6 H. Continued review of the lab result revealed the Nurse Practitioner initialed the lab result without the date or time the result had been reviewed. Interview with Licensed Practical Nurse (LPN) #8 on July 28, 2011, at 8:40 a.m., confirmed the Nurse Practitioner (NP) made rounds on March 2, 2011, and reviewed the labs from February 28, 2011. Continued interview confirmed the NP ordered the BMP to be completed the next day. Telephone interview with the NP on August 1, 2011, at 11:10 a.m., from the conference room confirmed, "It is possible I reviewed the labs from February 28, 2011, and ordered the BMP on March 2, 2011, during my rounds." Review of the Physician's Telephone Order dated March 2, 2011, revealed, "BMP in AM." Review of the resident's lab result dated March 3,	F 309	The IDT will validate that lab tests have been completed as ordered and follow-up is complete (physician and responsible party/resident notified) during afternoon clinical follow up meeting. Daily 3-11 charge nurses for 100, 200, 300 hall will pull lab results drawn that day by no later than 7pm. Abnormal labs will be communicated to the MD and resident and/or family member within 24 hours of the receipt of the results (This allows the nurse time to assess, document and make recommendations to the MD) Critical labs will be called to the facility by the lab and the nurse will immediately notify the MD within 15 minutes of receipt. If the attending physician does not respond within 15 minutes nurse will then notify Medical Director and Interim Director of Nursing.. Nurse will document that notification has occurred directly on the lab result form... The lab results will be filed in the medical record. In addition the charge nurse will update Lab Tickler Log to reflect the above. The Lab Tickler Tool will be initiated at the end of the month during the changeover process to reflect labs due for the upcoming month. The Interim Director of Nursing or designee and the Region Clinical Director will receive documentation of potential new admissions with orders for IV antibiotic therapy prior to admission to review medications and the method of administration. The Interim Director of Nursing and Region Clinical Director will jointly determine whether the facility has the resources to accept the referral. This joint review will continue for 60 days.	

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F 309	Continued From page 29 2011, revealed the potassium level was 6.0 H (high). Medical record review revealed no documentation the physician had been notified of the abnormal lab result on March 3, 2011. Continued review revealed the abnormal lab result had been faxed to the physician's office on March 7, 2011, (four days from the day the facility received the results). Interview with Registered Nurse (RN) #3 on July 26, 2011, at 2:15 p.m., in the conference room confirmed the RN found the abnormal lab result (potassium 6.0 H) dated March 3, 2011, "on the desk" on March 7, 2011, and faxed the result to the physician's office because RN #3 did not know if the physician had been made aware of the abnormal results. Interview with the resident's attending physician via telephone conversation on July 27, 2011, at 10:00 a.m., revealed the physician denied receiving the lab results. Continued interview confirmed the following interventions would have been in order had the physician received the elevated potassium results on March 3, 2011, of 6.0 H (high). 1) Review the resident's medications to ensure potassium was not being given; 2) Talk to the nurses; 3) Review the resident's diet and assessed hydration status; 4) Force fluids if needed; 5) Probably give oral Kayexalate (medication to reduce potassium levels in the blood stream). Telephone interview with the resident's attending physician on July 27, 2011, at 1:30 p.m., confirmed the physician's office had no record of	F 309	The IDT team will review the orders of residents admitted with Vancomycin antibiotic therapy and TPN during the morning meeting to assure that orders are transcribed properly and that orders are noted on the Lab Tickler Tool in accordance with the facility's lab process. Such review will continue for 60 days or until the IDT determines that the process is in place and working effectively through the QA and A process. On 7/27/11 the Region Clinical Director (RCD) and the Interim Director of Nursing initiated education for licensed nurses, certified nursing assistants, dietary staff and the registered dietician regarding the lab management system and the use of the Lab Tickler and Lab Audit Tools. Licensed nurses were educated by DON/SDC and RCD. Education began on July 28, 2011 regarding the Lab Process to include monitoring of Vancomycin levels and monitoring of labs associated with TPN administration. The education process will continue until licensed staff has been education. Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the new hire orientation process. The Interim Director of Nursing and/or designee initiated the process of educating licensed nurses on 8/2/11 regarding the proper method of administering Vancomycin and the importance of assuring appropriate monitoring of Vancomycin levels through lab results. Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the new hire orientation process.	

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F 309	Continued From page 30 any faxed notification of the abnormal potassium (6.0 H) lab result for March 3, 2011. Telephone interview on July 28, 2011, at 10:47 a.m., with the physician on-call March 3, 2011, denied knowledge of notification of the abnormal potassium level, but confirmed had the physician received notification of the abnormal potassium level of 6.0 H on March 3, 2011, the physician would have ordered treatment, "repeated the lab, maybe done an electrocardiogram (EKG), Calcium level, and sent to emergency room (ER)." Medical record review revealed no new physician's orders had been received as a result of the high potassium lab dated March 3, 2011. Review of the Nursing Daily Skilled Summary (nurse's note) dated March 8, 2011, at 10:00 a.m., revealed the resident complained of nausea and vomiting. Continued review of the narrative note from Licensed Practical Nurse (LPN) #8 revealed, "Rec'd (received) orders...to get CBC (complete blood count), CMP, UA (urinalysis) C&S (culture and sensitivity), and Zofran (an anti-emetic for nausea and vomiting) 4 mg (milligrams) po (by mouth) q (every) 6 hr (hours) prn (as needed) N/V (nausea and vomiting)." Review of the lab results dated March 8, 2011, revealed the resident had a critical potassium level of 8.4 H! (The exclamation point signified a critical level per telephone interview with the Lab Manager on July 27, 2011, at 10:25 a.m.) Continued review of the March 8, 2011, lab result revealed the lab representative informed Registered Nurse (RN) #2 of the critical	F 309	The Interim Director of Nursing and/or designee initiated the process of educating licensed nurses on 8/2/11 regarding the proper method of administering TPN and the importance of assuring appropriate monitoring of labs associated with TPN administration. Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the new hire orientation process. Licensed Nurses were educated on the 24-hour chart check process by the Staff Development Coordinator (SDC), which began on 8/2/11. Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the new hire orientation process. Nursing management and other clinical resources began the process of clinical competency testing of licensed nurses on administration of IVs, TPN, Trach care, etc. WHEN Nurses will be required to demonstrate competencies prior to being permitted to resume floor responsibilities. Nurses will not be permitted to resume regular work duties until competency testing is completed. Competency testing will be incorporated into the new hire orientation process. Licensed nurses will be educated by the Interim DON/designee regarding their responsibilities to assure labs are drawn timely. The licensed nurses are to obtain the blood sample in the event that the lab phlebotomist is unavailable in order to obtain the specimen timely. This will allow the facility to assure that the medication is administered according to	

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LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

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F 309	Continued From page 31 potassium level at 5:57 p.m. Review of the Nursing Daily Skilled Summary dated March 8, 2011, 6:00 p.m., revealed RN #2 received the critical lab information from the lab, and reported the critical lab result to RN #3. Review of the Nursing Daily Skilled Summary dated March 8, 2011, revealed RN #3 attempted to notify the physician through the physician's answering service at 7:00 p.m. Continued review of the nurse's note revealed the physician did not return the call until 7:45 p.m. Continued review revealed the physician ordered the resident to be sent to the emergency room for evaluation. Review of the physician's answering service call log dated March 8, 2011, revealed the physician on-call service did not receive the call until 7:50 p.m., with the message, "(resident name) very pail (pale) & (and) sick @ (at) stomach w/t (with) pain pls (please) call." Review of the nurse's note written by RN #3 dated March 8, 2011, revealed the emergency services transport had been called at 8:10 p.m. Review of the emergency services transport record revealed the call from the facility was received at 8:37 p.m. Continued review revealed emergency services (EMS) were at the facility at 8:50 p.m.; departed the facility at 9:14 p.m., and arrived at the emergency room (ER) at 9:17 p.m. Interview with RN #2 in the conference room on July 26, 2011, at 1:30 p.m., confirmed RN #2 had received the call from the laboratory at 6:00 p.m., with the critical lab result for resident #5.	F 309	physicians' orders Nurses will not be permitted to resume regular work duties until education is completed. Education will be incorporated into the new hire orientation process. Charge nurse for 100, 200 & 300 hall are responsible to report abnormal Vancomycin levels to the MD on the same day results of receipt for appropriate dosing by MD of next dose. MD notification should be documented directly on the lab results. The lab results should then filed in the Medical Record. Charge nurse for 100, 200 & 300 hall are responsible to report lab results for residents receiving TPN to the Pharmacy for recommendations of TPN dosing. Once dosing recommendations are received the Charge Nurse is to communicate recommendations to the MD that same day for the next day's TPN dosing instruction. MD notification should be documented directly on the lab results. The lab results should then filed in the Medical Record. The Division Director of Pharmacy Services has contacted the Consultant Pharmacist to remind him/her about his/her responsibility to review, during monthly visits, the use and possible discontinuation of Vancomycin antibiotic therapy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

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F 309	Continued From page 32 Continued interview confirmed RN #2 relayed the information verbally to RN #3, and solicited a response from RN #3 regarding understanding of information relayed. Continued interview with RN #2 confirmed RN #3 responded affirmatively. Interview with RN #3 in the conference room on July 26, 2011, at 2:15 p.m., confirmed the RN could not recall treatments, resident symptoms, or interventions provided for the resident during the length of time from 6:00 p.m. until 7:50 p.m., to call the physician's answering service; and from 7:50 p.m. to 8:37 p.m., to call the ambulance service. Telephone interview with Certified Nurse Aide (CNA) #5 on August 1, 2011, at 12:07 p.m., confirmed the CNA worked second shift (3 p.m. to 11:00 p.m.) had been assigned to care for resident #5 on March 8, 2011. Continued interview confirmed the resident was "okay" at 2:30 p.m. (beginning of shift). Continued interview confirmed the resident had complained about not feeling good around 4:00 p.m. Review of the Nursing Daily Skilled Summary written by RN #3, dated March 8, 2011, at 8:10 p.m., revealed, " ...Call placed to ambulance. Pt (patient) given a PRN (as needed) pain med (medication) for C/O (complains of) pain to lower ABD (abdomen) rated @ (at) 5 on a scale of 1-10 ..." Continued review revealed, "...8:50 p.m. ambulance here to pick up and transport to hospital..." Medical record review of the Medication Administration Record dated March 2011, revealed the resident had orders for	F 309	**4. Quality Assessment and Assurance Committee** The Quality Assessment and Assurance Committee will meet weekly for a month and monthly thereafter to discuss compliance with this plan and to review identified trends and patterns regarding the lab management system. The Committee includes the Medical Director, Administrator, DON, pharmacist, members of the IDT and at least one member of direct care staff. • Lab issue was identified on 5/11/11 during Quality Review Process: • Action plan was developed along with step-by-step lab process to address the lab system. It was brought to the May 18th QAA meeting as a identified concern/focus with action in process: • All licensed staff was educated on Lab Process and this education was completed by 6/8/11. • June QAA meeting held 6/14/11 also reflect action in progress related to the Lab process The Region Clinical Director will review the minutes of the Committee meetings weekly for one month and then quarterly thereafter to assure that appropriate discussion and follow-up is documented. Alleged Date of Compliance: August 16, 2011	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 33 "...Hydrocodone/Acetaminophen (narcotic pain medication) 5 mg - 325 mg, Take 1 tablet by mouth every 4 hours as needed for pain..." Medical record review of the Medication Administration Record dated March 2011, and the narcotics tracking log revealed no documentation the resident received the medication on March 8, 2011. Medical record review revealed no documentation of the transfer assessment or vital signs provided to the emergency medical transport services. Review of the emergency transport services report dated March 8, 2011, revealed, "...The call came in as critical labs. After arriving on the scene...called for assistance on a working code ..." (A code is the term used to define resuscitative measures performed in the absence of breath and/or pulse). Review of the emergency room Initial Assessment Form dated March 8, 2011, at 9:15 p.m., revealed, "...Cardiac arrest pre-hospital..." Continued review revealed the resident presented to the ER with CPR (cardiopulmonary resuscitation) in progress. Review of the hospital Code Blue Flow Sheet dated March 8, 2011, at 9:21 p.m., revealed, "...Type of Arrest...Cardiopulmonary, Hyperkalemia; Patient Diagnosis: Hyperkalemia, Ca (Cancer)..." Continued review revealed the time the code ended was 9:35 p.m. Review of the resident's death certificate revealed the cause of death was Acute Cardiac Arrest and Carcinoma of Bladder. Review of professional literature on potassium imbalance from the Diseases and Disorders	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 34	F 309		

Handbook, revealed, "...Because serum potassium level has such a narrow normal range (3.5 - 5 mEq/liter), a slight deviation in either direction can produce profound clinical consequences. Paradoxically, both hypokalemia (potassium deficiency) and hyperkalemia (potassium excess) can lead to muscle weakness and flaccid paralysis...Both conditions also diminish excitability and conduction rate of the heart muscle, which may lead to cardiac arrest..." Continued review revealed clinical features of potassium imbalance include nausea, diarrhea, and abdominal cramps.

Review of the facility's policy, Laboratory Management, revealed, "...If the results of the lab tests are Abnormal or Critical Values, the attending Physician/Licensed Provider will be notified immediately at the time the results are received. Date, time, and person notified should be documented on the lab report and signed by the Licensed Nurse...If a resident's primary care Physician/Licensed Provider (or their on-call coverage) cannot be reached to report a critical or abnormal value, the facility Medical Director or the Medical Director's NP (Nurse Practitioner)/designee and the DON (Director of Nursing)/designee will be contacted with the results."

Telephone interview with the resident's attending physician on July 27, 2011, at 1:30 p.m., confirmed the potassium level of 8.4 H! (critical) would have required emergency treatment.

Interview with the Director of Nursing on July 27, 2011, at 11:20 a.m., in the conference room confirmed the facility's policy for reporting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 35	F 309		

abnormal and critical lab values had not been followed. Continued interview confirmed the documentation was unclear as to why the resident had not been treated sooner.

In summary, resident #5 was admitted to the facility status post surgery, and with fluctuating lab values, specifically K+ (potassium), a critical element in the physiology of the rhythm of the heart. The resident was admitted for rehabilitation with the goal of returning home upon discharge. Lab results obtained on February 24 and 28, 2011, and March 3, 2011, indicated elevated and abnormal K+ levels for which physician notification on those dates cannot be verified. When the resident complained of nausea, vomiting, and abdominal pain (all indicators of elevated potassium) on March 8, 2011, new labs were ordered, and the critical potassium level of 8.4 was revealed. From the time the lab reported the critical K+ level to the facility at 5:57 p.m., on March 8, 2011, until the ambulance arrived at 8:50 p.m., 2 hours and 53 minutes of time elapsed, resulting in a delay in treatment. RN #3 stated the physician was notified as soon as he/she had been informed of the lab (around 6:00 p.m.) The physician's answering service call log indicated the call was not received until 7:50 p.m. (1 hour, 50 minutes) later. RN #3 stated the emergency transport services had been notified at 8:10 p.m. The emergency services transport services log indicated the call was received at 8:37 p.m. The failure of facility staff to follow facility policy in notifying the physician and calling for emergency medical services resulted in delay of treatment. Subsequently, as the resident was being loaded into the emergency transport, vital signs ceased,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 36	F 309		

and resuscitation measures began. Review of the Emergency Room records revealed resuscitation continued in the ER, without success. The resident died of Acute Cardiac Arrest at 9:35 p.m., on March 8, 2011.

Resident #12 was admitted to the facility on February 15, 2011, with diagnoses including Osteomyelitis (inflammation of the bone), Diabetes Mellitus, End Stage Renal Disease, Peripheral Vascular Disease, Hypertension, Backache, and Sepsis/Bacteremia (bacteria in the blood).

Review of the Admission Orders dated February 15, 2011, signed by the attending physician, revealed, "...Vancomycin 1000 mg (milligrams) IV (intravenous) once daily..." Continued review revealed, "...peak & (and) trough q (every) 3rd (third) dose. Pharmacy to dose..." Review of the resident's Medication Administration Record dated February 2011, revealed the resident received Vancomycin (an anti-infective used for serious or severe infections) 1000 mg (milligrams) intravaneously once daily.

Review of the facility's policy, Blood Sampling for Peak and Trough Values, revealed, "1. The peak is a measurement of drug in the blood after it has been given and at its highest level of concentration. Ideally 30-60 minutes following infusion. 2. The trough is a measurement of drug in the blood right before the next dose and at its lowest level of concentration in the blood. Ideally just prior to infusion...4. The ACTUAL TIME a specimen is obtained and the ACTUAL TIME the dose was hung is CRITICAL to accurately interpret drug levels for dosing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 37 considerations..." Review of the lab record dated February 18, 2011, and identified by the lab as "Trough" revealed a critical result of 37.1 H! ("!" indicates a critical lab value) with a reference range of 10.0 - 20.0. Continued review revealed the Medical Director had initialed the lab report and written "Stopped Vancomycin" with no time or date. Review of the Physician's Orders from February 15, through February 24, 2011, revealed no order to discontinue the Vancomycin. On February 24, 2011, the resident was readmitted to the hospital for acute exacerbation of chronic lower back pain. Review of the Medication Administration Record dated February 2011, and interview with Licensed Practical Nurse (LPN) #6 on August 2, 2011, at 7:30 a.m., in the conference room, confirmed the resident received daily doses of Vancomycin for February 15 - 24, 2011. Review of the Nursing 2010 Drug Handbook, revealed adverse reactions of Vancomycin include fever, pain, hypotension, pseudomembranous colitis, nausea, nephrotoxicity, and anaphylaxis. Continued review revealed, "...Patients with renal dysfunction need dosage adjustment. Monitor blood levels to adjust I.V. (intravenous) dosage. Normal therapeutic levels of Vancomycin are peak, 30 to 40 mg (milligrams)/L (liter) (drawn 1 hour after infusion ends), and trough, 5 to 10 mg/L (drawn just before next dose is given). Interview with the Medical Director on August 1, 2011, at 1:15 p.m., by telephone from the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 38	F 309		

conference room confirmed, "Was not aware the resident continued to receive the medication...Someone told me it had been stopped...I was not the patient's primary physician, but I pay attention to the labs...We have a kink in notification, signing what has been done...You know what they say, not documented, not done...That is a problem..."

In summary, the facility continued to administer an anti-infective (Vancomycin) for 6 days after the critical lab value was received.

Resident #13 was admitted to the facility on April 12, 2011, and readmitted on May 4, 2011, with diagnoses including Aspiration Pneumonia, Acute Renal Failure with Kidney Disease, Hypokalemia, Severe Volume Depletion, Malabsorption Syndrome, and Hyponatremia.

Medical record review of the TPN (Total Parenteral Nutrition)/PPN (Peripheral Parenteral Nutrition) Order Form, revealed the resident was admitted with "Custom Formula (specific ingredients, measured additives)" orders for TPN on May 4, 2011. Review of the Admission Orders dated May 4, 2011, revealed the lab tests for "CMP (Complete Metabolic Panel); Mag (Magnesium); CBC (Complete Blood Count) q (every) 3 days."

The definition of TPN provided by Taber's Cyclopedic Medical Dictionary is as follows: Provision of the total caloric needs by intravenous route for a patient who is unable to take food orally. Review of the Handbook for Geriatric Nursing Care revealed TPN is the parenteral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 39	F 309		

administration of dextrose, proteins, electrolytes, vitamins, and trace elements in amounts that exceed the patient's energy expenditure and thereby achieve anabolism (The building up of the body substance).

Review of the Dietary Progress Notes dated May 5, 2011, revealed, "...TPN to meet nutritional needs secondary to malabsorption syndrome...CMP/Mag(magnesium)/CBC q 3 days & communicate to MD (Medical Doctor) who will be managing TPN."

Review of the laboratory results from May 4, through May 13, 2011, revealed no labs had been completed on May 7, 2011, the first day the labs were due since the resident's admission on May 4, 2011.

Review of the resident's lab results dated May 10, 2011, revealed the following abnormal lab values: Blood Urea Nitrogen (normal: 8-24) 52 H (H= high); Creatinine (normal: 0.5-1.1) 1.2 H; BUN/Creatinine Clearance (normal: 6.0-25.0) 43.7 H; Glomerular Filtration Rate (normal: greater than 60) 55 L (L= low); Chloride (normal: 97-112) 91 L; CO2 (normal: 20-32) 35 H; Calcium (normal:8.7-10.4) 8.5 L; Total Protein (normal 6.2-8.0) 5.9 L; Albumin (normal: 3.2-5.0) 3.0 L; Alkaline Phosphate (normal: 35-105) 145 H; Red Blood Cells (normal: 3.8-5.0) 3.09 L; Hemoglobin (normal: 11.5-15.5) 9.0 L; Hematocrit (normal: 36-45) 27.5 L ...Continued review revealed no documentation the physician had been notified of the abnormal labs. Continued review revealed no changes in the TPN formula order.

Review of the resident's lab results dated May 13,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 40 2011, revealed the following abnormal lab values: Blood Urea Nitrogen (normal: 8-24) 45 H; Creatinine (normal: .5-1.1) 1.4 H; BUN/Creatinine Clearance (normal: 6.0-25.0) 32.2 H; Glomerular Filtration Rate (normal: greater than 60) 46 L; Chloride (normal: 97-112) 93 L; CO2 (normal: 20-32) 34 H; Calcium (normal:8.7-10.4) 8.3 L; Total Protein (normal 6.2-8.0) 5.3 L; Albumin (normal: 3.2-5.0) 2.6 L; Alkaline Phosphate (normal: 35-105) 163 H; PreAlbumin (normal: 17-34) 13.1 L; Glucose (normal: 73-107) 169 H ...Continued review revealed no documentation the physician had been notified. Continued review revealed no changes in the TPN formula order. Review of the facility's policy, Total Parenteral Nutrition Checklist, revealed, "...monitor labs frequently per physician's order and notify physician of any lab abnormalities or sudden changes. TPN formula may need to be adjusted..." Telephone interview with the Pharmacy Representative on August 2, 2011, at 10:55 a.m., in the conference room confirmed residents come from the hospital or home with initial TPN orders. The TPN orders are transcribed to the TPN standardized form (TPN/PPN Order Form), and sent to the physician for approval before the TPN formula is sent to the facility. Continued interview confirmed the pharmacy maintains care plans for each TPN resident, contacts the facility for order changes, and any formula changes made are a result of the physician's orders. Continued interview confirmed the initial formula is prepared from the TPN/PPN Order Form and subsequent formulas are based on labs (electrolytes, CBC,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 41 blood sugars) monitored by the Physician. Continued interview confirmed any changes in the TPN formula must come from the Physician. Telephone interview with the Pharmacy Representative on August 2, 2011, at 12:45 p.m., confirmed the pharmacy had no copies of labs in resident #13's care plan. Continued interview confirmed according to the pharmacy's care plan, the IV (Intravenous) Technician called the facility every other day, spoke with the nurse in charge of the resident, and inquired of physician changes to the orders for TPN. Continued interview confirmed no changes to the TPN orders had been communicated by the nurses to the pharmacy during the resident's stay in the facility. Interview with the Regional Clinical Director (RCD) #1 on July 29, 2011, at 3:00 p.m., in the conference room, confirmed there was no record of lab tests completed on May 7, 2011, as ordered by the physician. Telephone interview with the Medical Director on August 1, 2011, at 2:45 p.m., confirmed the resident had been admitted from the hospital on TPN. Continued interview confirmed the facility was responsible for obtaining the resident's labs and reporting the results to the physician to ensure the appropriate TPN formula. Continued interview confirmed the Physician's understanding was the facility faxed the lab results to the Pharmacy; the Pharmacy made recommendations based on the lab results for changes in the TPN formula; and the Physician approved the changes. Continued interview confirmed the physician was not aware the Pharmacy had not reviewed the lab results.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 42 Continued interview confirmed, "...No system is perfect...work toward effectiveness...learn from these mistakes...educate constantly..." Interview with RCD #1 and RCD #2 in the conference room on August 2, 2011, at 9:15 a.m., confirmed the TPN formula had not been changed as a result of the abnormal lab results at any time during the resident's stay. Interview with the Registered Dietician (RD) in the conference room on August 2, 2011, at 9:25 a.m., with RCD #1 and #2 present, confirmed the RD was not responsible for the TPN formula. In summary, the resident #13 was admitted with TPN orders, approved and signed by the physician. The physician ordered labs on admission to monitor the resident's needs regarding the TPN formula. The physician stated the pharmacy monitored the labs and would have made recommendations for changes. The pharmacy stated the physician monitored the labs and made changes. The May 7, 2011, lab had not been completed as ordered. The facility failed to provide care and services based on monitoring and review of lab results obtained on May 10 and May 13, 2011. Prior to formulating and dispensing TPN formula, the pharmacy records indicated a pharmacy representative contacted facility nurses to check for changes in the physicians orders. According the Pharmacy Representative, no changes were made to the TPN formula during the resident's stay at the facility. The resident was discharged to the emergency room on May 15, 2011, with complaints of shortness of breath and increased anxiety.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445268	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON HEALTH AND REHABILITATION CENTER	731 CASTLE HEIGHTS COURT LEBANON, TN 37087

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F 309	Continued From page 43	F 309		

Resident #14 was admitted to the facility on May 12, 2011, with diagnoses including Metastatic Prostate Cancer, T11 (Thoracic vertebrae #11) Compression Fractures with Cord Compression, Hypovolemia, and Hyponatremia.

Review of the Physician's Orders dated May 27, 2011, revealed an order for a CMP (Comprehensive Metabolic Panel) lab test to be completed on May 31, 2011.

Review of the lab results dated May 31, 2011, revealed the resident had abnormal lab values specifically a low potassium level of 3.4 with 3.6 - 5.4 identified as the normal range. Continued review revealed a notation on the bottom of the lab sheet, "...results called to Dr (doctor)..." and signed by the Licensed Practical Nurse (LPN). Continued review revealed an order, "40 meq (milliequivalents) po (by mouth) Potassium Chloride x (times) 1 now..."

Review of the Handbook of Geriatric Nursing Care, revealed, "...Potassium imbalances may result in such complications as muscle weakness and flaccid paralysis, and may also lead to cardiac arrest..."

Review of the Physician's Order dated June 3, 2011, revealed, "1. Give Potassium Chloride 40 meq (milliequivalents) 1 po (by mouth) now..."

Interview with the LPN #1 on August 1, 2011, at 9:05 a.m., in the conference room, confirmed the physician had not been notified of the May 31, 2011, lab result until June 3, 2011.

In summary, the facility failed to notify the

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F 309	Continued From page 44 Physician timely of abnormal lab results received on May 31, 2011, and not reported until June 3, 2011, resulting in a 3 day delay in treatment for the resident. The Immediate Jeopardy was effective from March 3, 2011, through August 3, 2011, and was removed August 3, 2011. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the survey team through review of facility documents, staff interviews, and observations conducted onsite on August 3, 2011. The survey team verified the allegation of compliance by: 1.) Reviewing the facility's plan for ensuring physician orders for lab work are processed and tracked to ensure the physician is notified of the results in a timely manner. Reviewing the facility's plan for auditing records to ensure staff are following the plan. Reviewing the facility's in-service records to ensure nursing staff have been or will be educated before resuming work regarding changes to and implementation of the facility's policy for processing, tracking, reporting, and monitoring labs. The Director of Nursing (DON) on site at the beginning of the survey resigned on July 29, 2011, and an interim DON had been appointed on August 1, 2011. 2.) Conducting interviews with 9 of 21 nurses on staff to determine the level of comprehension gained through in-service education conducted regarding the changes to the facility policy for ordering, receiving, reporting, and tracking lab	F 309		

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F 309	Continued From page 45	F 309		

results including the use of the Lab Tickler Tool for monitoring to ensure all labs are completed and reported timely. Continued interviews to confirm nurses were knowledgeable of the facility's process for reporting critical and abnormal labs to the physicians; knowledgeable of how to reach physician's after hours, and the time to wait for a call back from the physician; knowledgeable of who to contact if the physician cannot be reached or does not return the call timely.

3.) Reviewing additional charts for 3 of 4 residents currently receiving Vancomycin to ensure the medication is being administered according to the facility's policy and physician's orders; to ensure lab orders for peak and trough were documented on the Lab Tickler Tool for tracking. Interviewing nursing staff to ensure comprehension of the importance of the peak and trough labs, when each should be drawn, and who should draw the labs. Interviewing staff to ensure comprehension of the importance of administering the medication on a strict schedule and notifying the physician if unable to adhere to that schedule. Verifying resident careplans and cardexes included individualized interventions related to lab management.

4.) Reviewing additional charts for 1 out of 1 resident currently receiving TPN to assure the TPN is being administered according to facility policy and physician's orders; reviewing the new guidelines for dosing TPN which assigns the responsibility for notifying the pharmacy of the resident's lab results on the charge nurses assigned to each hall. Once dosing recommendations are received from the

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F 309	Continued From page 46 pharmacy, the charge nurse is responsible to communicate the pharmacy's recommendations to the physician and physician notification will be documented on the lab results. In addition the Lab Tickler Tool will be updated to reflectnotification and charting results. Verifying residents receiving TPN included labs ordered by the physician had been completed, and the results communicated to the attending physicians. Verifying resident careplans and cardexes included individualized interventions related to lab management. 5.) Reviewing 1 resident chart from random selection to ensure the critical lab result obtained from the pharmacy on August 3, 2011, was processed according to the amended facility policy for lab management. 6.) Reviewing the Addendum to the facility policy, Laboratory Management, regarding the timeliness of physician notification for abnormal and critical labs including specifics regarding the time to wait for a return call, and what to do if the physician does not return the call. Non-compliance continues at a "E" level for monitoring corrective actions. The facility is required to submit a plan of correction.	F 309		
F 514 SS=D	C/O # TN00027877 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	Continued From page 47 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to complete the medication administration record for one resident (#2) of nineteen residents reviewed. The findings included: Resident #2 was admitted to the facility on September 21, 2010, with diagnoses including Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with residual left hemiparesis, and Tracheostomy. Review of the Admission Assessment dated September 21, 2010, revealed the resident was alert to person, place, and time. Continued review revealed the resident had a feeding tube and a tracheostomy (trach). Review of the Minimum Data Set dated September 24, 2010, revealed the resident was able to make needs known, required extensive assist with transfers and dressing.	F 514	F514. The facility will maintain clinical records on each resident in accordance with accepted professional standards of practice that are complete; accurately documented; readily accessible; and systematically organized. 1.) **Resident #2** was discharged from the facility on 11/08/2010. 2.) The Interim Director of Nursing did not identify any active residents with tracheotomy care being provided on 08/15/2011. The Interim Director of Nursing audited Medication Records on current residents that were taking any Heparin, low molecular weight Heparin products, and Warfarin to assure the medication was being documented as ordered on 08/15/2011. 3.) The Director of Nursing instituted on 07/25/2011 a new monitoring tool that requires two nurses signatures assuring that the Medication Record is complete from shift to shift.	

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F 514	Continued From page 48 Review of the Medication Record (MR) for October of 2010, revealed the resident had orders for tracheostomy care every 8 hours. Continued review of the MR revealed blank spaces on the records where tracheostomy care should have been documented. Continued review revealed 24 of 93 opportunities for documentation of trach care were blank. Review of the MR dated October 2010, revealed the resident had orders for Heparin (anticoagulant medication) 5000 Units Sub-Q (subcutaneous) every 8 hours. Continued review revealed 16 of 93 opportunities for documentation of Heparin administration were blank. Interview with the Director of Nursing on July 25, 2011, at 2:40 p.m., in the conference room confirmed there were "holes in the medication record," and the medical record had not been completed. C/O #TN00027036	F 514	The Director of Nursing or Designee is auditing 100% of all Heparin, low molecular weight Heparin products, and Warfarin to ensure compliance daily for two weeks, weekly for one month, monthly for three months, and then quarterly thereafter. The IDT Team is auditing 100% of all Medication Records to ensure compliance daily for two weeks, weekly for one monthly, monthly for three months, and then quarterly thereafter. Licensed nurses were educated by the DON, SDC, and Regional Clinical Director 7/25/2011 on the Medication Administration process. The education will continue until all nurses have been educated. Licensed nurses will not be able to resume regular work duties until education has been completed. The educational materials have been incorporated into the new hire orientation program. 4.) The data collected from the audit will be given to the Director of Nursing for tracking and trending. The Director of Nursing will present the trended data to the Quality Assessment and Assurance Committee during its monthly meeting. Compliance of the system will be reviewed monthly by the Quality Assessment and Assurance committee, which consists of the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Medical Records, Dietary Manager, Rehab Director, Resident Care Management Director, Pharmacist Consultant, Maintenance Supervisor, Social Services Director, Activity Director, and Housekeeping Supervisor. Additional measures will be developed and implemented as needed. Alleged Date of Compliance: August 16, 2011	